MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012386
STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 80

FILED MAR 27 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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DATE AMENDED | ITEM NO. | SHOULD READ | INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe
Length of stay in 1b: 1 mo
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Swans Rest Home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Sullivan
c. CITY OR TOWN Osgood
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LENNIE Middle R. Last TODD

4. DATE OF DEATH: Month 3 Day 21 Year 1963

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 7-27-1881

9. AGE (last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeping

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Sullivan Co Mo

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Wm L. Scott

13b. MOTHER'S MAIDEN NAME: Margaret Willis

14. NAME OF HUSBAND OR WIFE: Wm Allen Todd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs John Bachner Address: Humphreys Mo

18. CAUSE OF DEATH (Enter only one cause p
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Epithelioma of Nose

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-26-63 to 3-21-63 and last saw her/him alive on 3-21-63
Death occurred at 6:10 Pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J M Powell, M.D.

22b. ADDRESS: Chillicothe Mo

22c. DATE SIGNED: 3/27/63

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-24-1963

23c. NAME OF CEMETERY OR CREMATORY: Camp Ground Cem.

23d. LOCATION (City, town, or county) (State): Osgood Mo

24. FUNERAL DIRECTOR ADDRESS: Payne Funeral Home, Galt Mo.

25. DATE RECD. BY LOCAL REG.: Mar 22, 1963

26. REGISTRAR'S SIGNATURE: Annalee Taylor

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed D K Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.